Healing Source Chiropractic
Your Source for Health and Wellness

3961 E. Lohman Ave Ste 22
Las Cruces, NM 88011
(575) 652-3358

Ages 6 to 18

Today's Date: _____

Name:	Date of Birth: Sex: Male Female
Mailing Address:	Parent/Guardian Names & Phone Numbers:
Phone Number with Area Code:	E-Mail:
Hobbies & Sports you enjoy:	Family Medical Doctor:
Referred by: please list person's name ○ Friend/Family ○ M.D. / D.C. ○ Internet/Add	
Have you had chiropractic care before? If so, when and by whom?	
Insurance Carrier: ID Number: Group Number:	Primary Policy Holder Name (if not yours): Policy Holder Date of Birth:

Healing Source Chiropractic focuses on your ability to be healthy. Our goals are to **first** address the issues that brought you to this office, and **second**, offer the **opportunity to improve your health potential in the future**. In order to give you the best possible chiropractic care, we will need to discover any **stresses** that are placed on your body. Please take the time to fill out this form completely, as each question gives us a clearer picture of your current health status.

Reason for consulting Healing Source Chiropractic: ○ Wellness / Prevention Care - I wish to continue my chiropractic wellness care.
○ A current problem

Please describe your current problem, including the effect it has had on your life:

Please describe the character of your pain, check all that apply:

Sharp/Stabbing	Sharp/Dull	Achy	Dull	Soreness	Weakness
Throbbing/Gnawing	Numbness	Shooting	Gripping/Constricting		
Burning	Tingling	Other_____			

How bad is your pain or ache?

0 1 2 3 4 5 6 7 8 9 10

no pain unbearable pain

How often are the complaints present?

○ Constant: 76-100% ○ Frequent: 51-75% ○ Occasional: 26-50% ○ Intermittent: 25% or less

When is the pain or symptom worse?

○ When you wake up ○ During the day ○ After work ○ In the evening ○ After eating ○ While sleeping

Since your problem began is the pain: ○ increasing ○ decreasing ○ not changing

When did your problem begin?_____(specific date of possible)

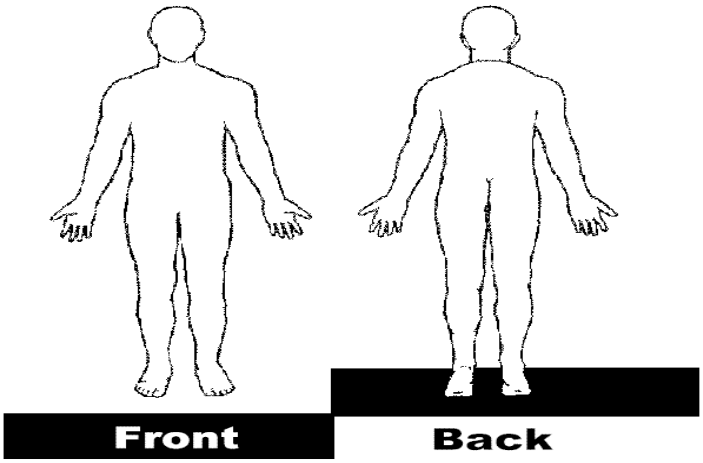
Do you sleep on your: ○ Back ○ Stomach ○ Left Side ○ Right Side

Physical activity at work: ○ sitting more than 50% ○ Light manual labor ○ Heavy manual labor

General physical activity: ○ No regular exercise program ○ Light exercise program ○ Strenuous exercise program

Rate your stress level: ○ No stress ○ Minimal stress ○ Moderate stress ○ Greatly stressed

Draw on the diagram where you feel your symptoms



Do you currently smoke? Yes No if YES how many packs a day:_____ Number of years:_____

Describe any falls, auto accidents or major injuries - include month & year and type of accident:_____

_____

_____

Describe all past surgeries:_____

_____

List ALL medication that you are currently taking – prescription and over the counter:_____

_____

Personal History: Please circle all that apply: Aneurysm Osteoporosis Diabetes Thyroid Disease Arthritis Cancer Stroke Heart Condition Hypertension Polio Asthma Psoriasis. Other:_____

Family History: Please circle all that apply: Aneurysm Osteoporosis Diabetes Thyroid Disease Arthritis Cancer Stroke Heart Condition Hypertension Polio Asthma Psoriasis. Other:_____

Please check all symptoms or areas where you have problems, even if they do not seem related to your current problem:

○ Headaches/Migraines	○ Buzzing/Ringing in Ears	○ Lungs	○ Low Back Pain
○ Dizziness	○ Fatigue	○ Heart	○ Hip Pain
○ Eyes/Vision	○ Fainting	○ Stomach	○ Leg Pain/Cramps
○ Concentration Loss	○ Sinus	○ Indigestion	○ Poor Circulation
○ Depression	○ Neck Pain/Stiffness	○ Bladder	○ Numb Felling
○ Nervousness	○ Feeling of Pins/Needles	○ Liver	○ Shoulder
○ Sleeping	○ Upper Back	○ Colon	○ Hot Flashes
○ Loss of Energy	○ Mid Back	○ Kidney	○ Cold Sweats
○ Tired Mornings	○ Chest Pain	○ Constipation	○ Diarrhea
○ Loss of Taste/Smell	○ Menstrual Pain/Irregularity	○ Urination	○ Fever

Do you drink bottled or filtered water: Yes No

How much water do you drink in a day?_____

How many servings of fruit and vegetables do you eat on a typical day?_____

If you remember the detail, what was your birth delivery like – breach, C-section, long:_____

Have you had any or all of your childhood vaccinations?_____

Did you have any reactions to vaccinations? Yes No

Please list all supplements and vitamins you take:_____

How many hours a day do you spend in front of: _____computer _____tv _____gaming

How many hours a day to you exercise?_____

How would you rate your health:

1 2 3 4 5 6 7 8 9 10

I have never felt worse — I feel great!

What is your goal or expectation with chiropractic care?_____

_____

I hereby authorize the doctor to examine and treat my condition as deemed appropriate through the use of chiropractic care and I give authority for these procedures to be performed. I have been informed of the financial policy and agree that I am responsible for all expenses incurred at Healing Source Chiropractic. I have had an opportunity to review the privacy policy and agree to its terms.

Patient Name (printed):_____

Parent/Guardian Name (printed):_____

Parent/Guardian Signature:_____ Date:_____

Terms of Acceptance for Healing Source Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. Chiropractic has only one goal. It is important that each patient understands both the objectives and the methods which will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An Adjustment is the specific application of forces to facilitate the body's correction of spinal nerve interference. Our chiropractic method of correction is by specific adjustments of the spine.

Health: Health is a state of optimal physical, mental and social well-being, not merely the absence of illness.

Vertebral Subluxation, also known as spinal nerve interference: A misalignment of one or more of the 24 vertebra in the spinal column which causes alterations of nerve functions and interferes with the transmission of mental impulses, thereby lessening of the body's innate ability to express its maximum health potential.

We do not diagnose nor treat any disease or condition other than vertebral subluxation. If, however, we encounter non-chiropractic or unusual findings during the course of your chiropractic spinal examination, we shall advise you. If you desire advice, diagnosis or treatment for those findings, we shall recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our only practice objective** is to eliminate a major interference to expression of the body's innate wisdom. Our only methods are specific adjustments to correct vertebral subluxations.

All questions regarding the Doctor's objectives pertaining to my care in this Office have been answered to my complete satisfaction. Occasionally HSC will send you our email newsletter and/or office announcements. If you do not wish to receive these announcements, you may unsubscribe at any time.

I therefore accept chiropractic care and the HSC policies on this basis.

I (print name)_____, have read and fully understand the above statements.

Signature_____ Date_____

Consent to Evaluate and Adjust a Minor

I _____being the parent or legal guardian of (print name)_____

I have read and fully understand the above terms of acceptance and hereby grant permission for my child/legal dependent to receive chiropractic care.

Signature of Parent/Guardian_____ Date_____

Financial Policy for Healing Source Chiropractic

Members without health insurance will be asked to pay for treatments in full at the time of service.

If you have health insurance, we shall attempt to verify your chiropractic benefits. If HSC is in network with your insurance company, we shall collect your co-payment and file with your company. Once the claim is processed, HSC will refund any credit to you or apply such credit towards future treatments. If there is a balance, you will be billed accordingly.

Any balance on your account over 60 days may be sent to a collection agency in addition to a $25.00 collection fee.

There is a charge for any missed appointments without a 24 hour notice.

I have read the financial information and agree to abide by these terms and conditions.

Signature_____ Date_____

Notice of Informed Consent

Healing Source Chiropractic

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about chiropractic care and the potential problems associated with it before consenting to treatment.

Subluxation is a medical term that describes what occurs when one or more of the spinal (vertebral) joints have moved out of their normal alignment. This can occur through recent or remote trauma as well as unusual positions we may find ourselves in throughout the day or night. A subluxation has also been described as an incomplete dislocation of a joint, and, as such, is not treated with drugs or surgery. Chiropractors treat vertebral subluxation with spinal manipulations (adjustments performed by hand or with the use of a specific tool) in order to gently reposition the misaligned segments. Frequently, adjustments create a popping or a clicking sensation in the area being treated.

Stroke: Recent reports have shown an elevated incidence of stroke is seen equally in chiropractic and medical physician offices (Cassidy, 2008); supporting the theory that patients are presenting with a stroke, and not that chiropractors or medical physicians are causing a stroke.

Disc Herniation: Disc herniations that create pressure on the spinal nerves or the spinal cord in the neck or low back are treated successfully by chiropractors with adjustments and spinal decompression. Occasionally, these treatments can irritate this problem. Patients are thoroughly examined to determine the best course of treatment. Disc herniation complications occur so rarely there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue refers primarily to the muscles, tendons, and ligaments. Muscles move bones, and ligaments limit joint movement. Rarely, a chiropractic adjustment, traction, massage, and other treatments may strain some muscle or ligament fibers. These possible injuries also occur so rarely there are no available statistics to quantify their probability.

Rib Fractures: Your ribs are attached to the thoracic spine in the middle back. They extend from your back to the front of your chest. Rarely, a chiropractic adjustment may break a rib. This could possibly occur only to those patients with weakened bones. It is your responsibility as the patient to inform your doctor of any history of osteoporosis, prolonged steroid use, or other bone-weakening diseases. Rib fractures also occur so rarely there are no available statistics to quantify their probability.

Soreness: It is not uncommon for spinal adjustments, Active Release Therapy, exercise, and other therapies to result in a temporary increase in soreness to the area being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please inform the doctor if you experience soreness.

At Healing Source Chiropractic we employ highly-trained staff to assist the doctors with portions of your consultation, examination, exercise instruction, and other treatments. Occasionally, when your doctor is not available, another Healing Source doctor will be available to treat you.

Any questions on the above information should be directed to your doctor. When you have a full understanding of this material, please sign and date below.

Authorize to Treat: I, the undersigned, hereby authorize all Healing Source doctors and whomever they designate to administer chiropractic, physical therapy, and/or therapeutic treatment or medical procedures they consider necessary on the basis of findings during the set course of treatment.

Patient Name:_____ **Date:**_____

Patient Signature:_____ **Witness:**_____

Consent for Treatment of a Minor: I, the undersigned, hereby authorize all Healing Source doctors and whomever they designate to administer chiropractic, physical therapy, and/or therapeutic treatment or medical procedures they consider necessary on the basis of findings during the set course of treatment to:

Minor Child's Name:_____ **Date:**_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ **Witness**_____